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FILED
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OFFICE OF THE CLERK

No.

IN THE
SUPREME COURT OF THE UNITED STATES

UNITED STATES OF AMERICA, *EX REL*, J. EDWARD WALTERS,

Petitioner,

v.

THE DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM, PROVIDENCE HOSPITAL, SETON MEDICAL MANAGEMENT, INC., AND ASCENSION HEALTH, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

SUPPLEMENTAL APPENDIX CONTAINING DISTRICT COURT OPINION

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IN THE UNITED STATES DISTRICT COURT
FOR THE
SOUTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

UNITED STATES OF AMERICA, *ex rel.* J. EDWARD WALTERS, Plaintiff,	)	
v.	)	CIVIL ACTION NO. 99-0932-CB-C
THE DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM, PROVIDENCE HOSPITAL, SETON MEDICAL MANAGEMENT, INC., and ASCENSION HEALTH, INC., Defendants.	)	

MEMORANDUM OPINION and ORDER

This action involves a *qui tam* claim under the False Claims Act (FCA), 31 U.S.C. §§ 3729-33, by relator Edward Walters arising from Medicare reimbursements claims submitted by defendant Providence Hospital. Defendants have filed a motion to dismiss the second amended complaint ("the complaint") for failure to plead fraud with particularity and for failure to state a claim. In response to the motion, Walters asserts that his claim is both properly pled and legally sufficient. After reviewing the complaint and the issues raised in light of the applicable law, the Court finds that the motion to dismiss is

due to be granted.

Facts

J. Edward Walters was formerly Director of the Diabetes Center, Director of the Cholesterol Center and Director of the Employee Assistance Program at Providence Hospital in Mobile, Alabama. Walters was employed by Providence Hospital from March 1988 through March 1998. According to the complaint, Providence terminated Walters' employment shortly after he uncovered the billing practices that are the subject of this lawsuit.

Defendant Providence Hospital, a not-for-profit corporation incorporated under the laws of Alabama, is located in Mobile, Alabama. During the time relevant to this action, Providence provided health care services to beneficiaries of Medicare, Medicaid, and other federally-funded programs and was a Participating Provider with the United States Health Care Financing Administration (HCFA) and its successor agency, the Center for Medicaid Services (CMS). According to the complaint, defendants Seton Medical Management, Inc. (Seton), and Daughters of Charity National Health System (Daughters of Charity) participated in the management and/or ownership of Providence, and defendant Ascension Health, Inc. (Ascension) is the successor-in-interest to Daughters of Charity.

In January 1998, each department head at Providence became responsible for his or her department's billing, including responsibility for the accuracy of billing. Walters began to review bills and medical records for prior patients. Comparing patients' bills with medical records, Walters noticed "that patients were billed for certain drugs and other supplies which were not actually administered to them." Second Am. Compl ¶ 14. Walters "reviewed a number of

patients' bills and records which followed the same pattern of charges for drugs and supplies not received[.]" *Id.* ¶ 15. According to Walters, "the process of overbilling for drugs and medical supplies which were not actually received by the patients was part of the billing system which contained little if no [sic] procedures to credit a patient's account for drugs and medical devices which were initially charged to the patient, but were not actually received." *Id.* ¶ 42.

Walters copied only one patient's record, and, therefore, his only reference to specific instances of overcharges relate to that patient, whom the complaint refers to as "F.G." For F.G.'s hospital stay from June 4-10, 1997, the total amount of overcharges for drugs and medical supplies, by "[a] conservative estimate[,]" was $1,185.03. *Id.* ¶ 35. On June 17, 1997, Providence submitted to the Medicare Intermediary a claim for services rendered to F.G. which included the $1,185.03 in overcharges.

Providence did not receive payment from Medicare for those overcharges, however, due to the method of reimbursement used under the Medicare system. In fact, those charges were not used in any way to calculate the amount owed to Providence for F.G.[1]

Near the end of 1997, Providence submitted an annual Cost Report covering the period from July 1, 1996 through June 30, 1997. That Cost Report, which is attached to and made part of the complaint, sets out total annual costs for "Medical Supplies" and "Drugs Charged to Patients" at approximately $3.3 million and

[1] The Medicare reimbursement system is explained in more detail in the legal analysis section, *supra* p. 7.

$3.6 million, respectively.

Procedural Background

This action, which is brought under the False Claims Act, was filed on April 19, 1999, naming as defendants Daughters of Charity National Health System, Inc., d/b/a Providence Hospital and Seton Medical Management, Inc. Pursuant to 31 U.S.C. § 3730(b)(2), the case was sealed prior to the service of process to allow the government an opportunity to investigate and decide whether to intervene. The sealed period was extended several times at the government's request 31 U.S.C. § 3730(b)(3). In August 2001, the government filed notice that it did not intend to intervene. (Doc. 17.) Due to questions regarding plaintiff's legal representation, the sealed period was further extended until March 28, 2002, when an order was entered unsealing the case and requiring service upon the defendants.

On May 15, 2002, plaintiff filed a first amended complaint adding Ascension Health, Inc. as a defendant. Subsequently, all defendants filed motions to dismiss. In response, the plaintiff filed a motion for leave to amend the complaint.[2] The Court granted the motion for leave to amend and terminated the pending motions to dismiss without prejudice to defendants' right to file new motions to dismiss. Subsequently, defendants filed the motion to dismiss *sub*

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[2] While this action was pending, *United States ex rel. Clausen v. Laboratory Corp.*, 290 F.3d 1301, 1310 (11th Cir. 2002), *cert. denied* 537 U.S. 1105 (2003), was decided. In light of the *Clausen* decision, plaintiff concluded that it was necessary to file a second amended complaint in order to comply with the pleading requirements of Fed. R. Civ. P. 9(b). The Court permitted the amendment and informed the defendants that motions to dismiss would more appropriately be directed at the second amended complaint.

judice.

Issues Presented

Defendants raise two common issues in their motion to dismiss.[3] First, they argue that the complaint is due to be dismissed with particularity as required by Fed. R. Civ. P. 9(b). Second, defendants contend that the complaint does not state a claim upon which relief can be granted. In opposing the motion to dismiss, plaintiff argues that the complaint sufficiently states three potential FCA claims, all of which arise from the hospital's alleged practice of overcharging for prescription medicines and medical supplies: (1) inflation of the total cost of prescription medicines and medical supplies set out in the annual cost report submitted to Medicare by including overcharges to F.G. (2) inflation of the total cost of prescription medicines and medical supplies set out in the annual cost report submitted to Medicare due to a "systemic" practice of overcharging and (3) inflation of a category of costs known as "outlier costs" in the annual cost report submitted to Medicare.

LegalAnalysis

Before addressing these issues, some background in the

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[3] Defendants Daughters of Charity, Seton and Ascension raise additional grounds for dismissal based on plaintiff's failure to plead facts demonstrating their participation in the alleged fraud. Plaintiff's claims against these defendants are not, however, based upon their direct participation but on theories of derivative liability. Plaintiff contends that Daughters of Charity and Seton are either principals or agents of Providence and that Ascension is liable as a successor-in-interest to Seton. The Court need not consider the separate issues raised by these defendants, however, since plaintiff's ultimate success against them depends upon his ability to state a claim against Providence.

applicable law is necessary. The Court will first consider the standards of review governing motions to dismiss under Fed. R. Civ. P. 9(b) and 12(b)(6). Next, in order to determine whether a claim has been stated, the Court must determine the precise elements of a cause of action under the FCA. Finally, application of the standards of review and the FCA in this case requires a general understanding of the Medicare reimbursement system.

Rule 9(b) & Rule 12(b)(6)

Because the FCA is a fraud statute, the pleading requirements of Fed. R. Civ. P. 9(b) apply. "Thus, ... a plaintiff must plead 'facts as to time, place and substance of the defendant's alleged fraud,' specifically 'the details of the defendants' allegedly fraudulent acts, when they occurred and who engaged in them.'" *Clausen v. Laboratory Corp.*, 290 F.3d at 1310. In *Clausen,* the Eleventh Circuit upheld the dismissal of a complaint for failure to plead an FCA claim with particularity.

A motion to dismiss under Rule 12 (b)(6) may be granted only "when the movant demonstrates 'beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.'" *Harper* v. *Blockbuster Entertainment Corp.*, 139 F.3d 1385, 1387 (11th Cir. 1998) (quoting *Conley v. Gibson,* 355 U.S. 41, 45-46, (1957)). In general, for purposes of a motion to dismiss, the Court must accept all the allegations of the complaint as true and construe the facts asserted in the light most favorable to the plaintiff. *Fortner v. Thomas,* 983 F.2d 1024, 1028 (11th Cir. 1993). However, allegations contradicted by facts set out in exhibits attached to or incorporated into the pleadings need not be taken as true. *United States ex rel Wilkins v. North American Constr. Corp.*, 173 F.Supp.2d 601, 617 (S.D. Tex. 2001).

Elements of a False Claims Act Claim

Plaintiff's lawsuit is brought under 37 U.S.C. §§ 3729(a)(1) and (a)(2) of the False Claims Act. Subsection (a)(l) makes it unlawful "to knowingly present or cause to be presented to an officer or employee of the United States Government ...a false or fraudulent claim for payment or approval." Subsection (a)(2) makes it unlawful "to knowingly make, use or cause to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the Government." Thus, in order to state a claim plaintiff must allege, at a minimum, facts to support the following elements: (1) the defendants made a claim or made a record or statement in support of a claim, (2) the claim or record or statement was false or fraudulent and (3) the defendants knew of its falsity. Submission of a false statement alone does not give rise to liability arises under the False Claim Act. *United States v. Southland Management Corp.* 326 F.3d 669, 674 (5th Cir. 2002) (en banc). "It is only those claims for money or property to which a defendant is not entitled that are 'false' for purposes of the False Claims Act" *Id.* 674-75. "There is no liability under this Act for *a false statement* unless it is used to get *a false claim* paid" *Id.* at 674 (emphasis added).

Every circuit court that has addressed the issue directly has held that the False Claims Act claim also requires proof of a fourth element-that the false submission was material.[4] *See, e.g., United States v. Southland Management Corp.* 326 F.3d 669, 679 n.3 (5th Cir. 2002) (en banc) (Jones, J., concurring) (collecting cases); *Hays v. Hoffman,* 325 F.3d 982

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[4] The Third Circuit has, in *dicta,* questioned whether materiality is an element of an FCA claim. *See United States ex rel. Cantekin v. University of Pittsburgh,* 192 F.3d 402, 415 (3rd Cir. 1999).

(8th Cir. 2002); *Luckey v. Baxter Healthcare Corp.*, 183 F.3d 730, 732 (7th Cir. 1999); *United States ex rel. Berge v. Board of Trustees of the University of Alabama,* 104 F.3d 1453 (4th Cir. 1997); *see also United States v. TDC Management Corp., Inc.*, 24 F.3d 292, 298 (D.C. Cir. 1994) *(dicta).* Following the reasoning of these courts, this Court also concludes that a false claim must be material in order to be actionable under the FCA.

Medicare Reimbursement System

To determine whether any of plaintiff's claims allege a cause of action under the FCA, it is necessary to understand, first, how the Medicare reimbursement system operates. Medicare does not reimburse a healthcare provider for the actual charge submitted, nor is the reimbursement based upon that amount. Instead, "Medicare groups standardized medical codes for patients, diseases, and procedures into diagnostic related groups ('DRG') that provide the basis for [the] PPS [prospective payment system]. The average cost of care for each DRG determines the reimbursement amount, rather than the actual cost of care to a beneficiary." *United States v. Whiteside,* 285 F.3d 1345, 1346 (11th Cir. 2002). Health care providers are reimbursed at a preestablished flat rate for each DRG. *Transitional Hosp. Corp. of Louisiana, Inc. v. Shalala,* 222 F.3d 1019, 1021 (D.C. Cir. 2000). The reimbursement rates are based "on national and regional averages for the cost of treating particular illnesses and... not.. .on the cost to any particular hospital of treating particular DRG- classified illnesses." *Huntington Hosp. v. Thompson,* 319 F.3d 74, 76 (2nd Cir. 2003) (citing 42 U.S.C. § 1395ww(d)(l)(D)). In the case of patients whose hospital stays are "extraordinarily lengthy or costly" Medicare provides for additional reimbursements known as "outlier payments." *Transitional Hosp.,* 222F.3d at 1021.

Annual cost reports submitted by the health care provider are part of the reimbursement equation because they include certain costs, such as outlier costs, that may be reimbursed by Medicare in addition to those costs taken into account in the PPS/DRG payments. "[The] provider files annual cost reports setting forth information and calculations identifying the Medicare costs [such as outlier costs] that the hospital claims should be reimbursed by Medicare for that year. The cost reports include a certification that each cost report filed is true, correct, complete, and prepared from the books and records of the provider." *Id.*

General Allegations of Overbilling do not Satisfy Rule 9(b)

Plaintiff's claim regarding "systemic" overbilling by Providence is insufficient under Rule 9(b). There are no specific allegations as to time or place and only general allegations as to substance. In *Clausen,* the Eleventh Circuit held that the complaint under the FCA must allege, with particularity, at least one instance of a false claim being submitted. *Clausen,* 290 F.3d at 1312. Setting aside allegations with respect to F.G., which are discussed below, plaintiff has alleged: (1) that he is aware of other instances of overbilling for drugs and medical supplies based on his review of hospital records and (2) that "because these types of overcharges are systemic..., the Cost Report is greatly overstated as to drugs and medical supplies for patients." These are a series of conclusions, not facts. One cannot necessarily infer that the overbilling of particular charges to patient accounts is actually reflected in the cost report based simply on plaintiffs broad and conclusory allegations. Plaintiff has failed to make a specific allegation that the alleged "systemic" practice of overbilling resulted in the submission of a false claim for payment.

Even Specific Allegations of Overbilling do not Satisfy Rule 12(b)(6)

On the other hand, plaintiff's claim with respect to F.G. is specific with respect to time, place and substance of the alleged fraud and is, therefore, pled with sufficient particularity to satisfy Rule 9(b). However, neither this specific claim nor the more general claim discussed above states a claim upon which relief can be granted because it is apparent from the facts alleged and from the documents incorporated into the complaint that the alleged overcharges for medicine and medical supplies were not material to any claim for payment. A statement is material if it "has a natural tendency to... or is capable of influencing" the agency's decision whether to pay the claim. *Harrison,* 176 F.3d at 785.[5] First, it should be noted that with respect to F.G. plaintiff's claim is not based on any direct connection between the charges submitted to the fiscal intermediary and the specific payment to Providence for F.G.'s treatment. Whether those charges were true or false is irrelevant under the Medicare system because they did not affect the reimbursement decision. Any overcharges submitted with respect to F.G. (or any other individual) had no possibility of influencing the DRG

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[5] Some courts have relied on an alternative definition of materiality found in the Restatement (Second) of Torts § 538 (1977), which provides that a false statement is material if "a reasonable man would attach importance to its existence" or if the person making the statement knows or has reason to know that the recipient is likely to attach importance to it when making his decision. *Wilkins,* 173 F.Supp.2d at 635. Plaintiffs claim fares no better under this standard. A reasonable person would not attach importance to the amount of the statement submitted for payment where the amount of payment bears no relation to the amount claimed. Further, there are no facts asserted from which one might infer that Medicare or its fiscal intermediary attached any importance to the amount charged by Providence.

payment because that payment is fixed according to a reimbursement rate predetermined by Medicare.

Plaintiff alleges that the inflated amounts submitted are material in a broader sense. According to the complaint, these inflated charges for drugs and supplies were factored into the annual cost report, which then became the basis for "the computations considered by the Healthcare Financing Administration... which help to determine reimbursement rates for hospitals."[6] This allegation does not support materiality for two reasons.

First, the allegation is contradicted by the annual cost report itself. To demonstrate the method of the fraud, *i.e.,* that overcharges for drugs and medical supplies were included in the annual cost report, plaintiff has included with the complaint both the annual cost report and portions of a *worksheet* that was attached to that report. Plaintiff points out that on Worksheet A "Medical Supplies Charged to Patient" (item 55) are $3,329,717 and "Drugs Charged to Patients" (item 56) are $3,540,291. According to plaintiff, the amounts overcharged to F.G. and to other patients must be included in these worksheet totals. Therefore, plaintiff contends that the cost report is inflated. The trouble with plaintiffs theory is that the worksheet is not the cost report. These items-medical supplies and drugs-are listed on the worksheet under the heading "Ancillary Service Cost Centers," but those costs are not actually claimed on the annual cost

[6] The Court questions whether the inclusion of such data in a subsequent cost report would fulfill the FCA requirement that the statement be made "in support of a claim" since individual claims are submitted throughout the fiscal year and the report is not used to determine DRG reimbursements for the prior year.

report.[7] The cost report lists the "Ancillary Service Pass Through Cost" filed as $0. Because these overcharges were not actually claimed on the cost report, no false claim was submitted.

Even if overcharges for medicine and medical supplies had been included in the cost report, they would not support an FCA claim because, insofar as that report is concerned, these overcharges are not a claim for payment. As discussed above, plaintiff's theory is that inclusion of these overcharges on the annual report became part of the data used by Medicare to determine the amount of future DRG reimbursements rates. Submitting false data unrelated to a claim for payment is not prohibited by the FCA.

Plaintiff's Claim not Asserted in Complaint

In response to the motion to dismiss, plaintiff has conceived a new false claim theory not asserted in the complaint. According to this theory, the practice of overbilling may have been reflected in "outlier" payments which are a part of the cost report. Plaintiff admits that there were no outlier payments for F.G. but speculates that there may have been such payments for other patients as a result of overbilling. Because evidence that would support plaintiff's theory is

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[7] Plaintiff s complaint included only one page of the Worksheet A, which begins with line 41 and includes "Medical Supplies Charged to Patients" and "Drugs Charged to Patients" on lines 55 and 56. Along with its motion to dismiss, defendant has provided a complete copy of Worksheet A, from which it is clear that lines 37 through 59 are "Ancillary Cost Centers." When a plaintiff refers to documents central to the complaint, the Court will consider those documents *in their entirety* as part of the pleadings, even where the documents were not made a part of the complaint *Cf. United States ex rel. Brooks v. Blue Cross and Blue Shield of Florida, Inc.*, 116 F.3d 1364, 1369 (11th Cir. 1997) (on Rule 12(b)(6) motion permissible to consider documents provided by defendant as part of pleadings because those documents were central to complaint).

exclusively within defendants' control, plaintiff argues that the pleading requirements of Rule 9(b) should be relaxed to allow his claim to proceed

The difficulties with plaintiff's proposal to proceed with the unpled claim are twofold. First, neither the complaint, the amended complaint, nor the second amended mentions the outlier theory. This is not a claim that plaintiff has merely failed to state with particularity; rather, it is a claim that plaintiff has failed to assert at all. Plaintiff has offered no excuse for his failure to assert claim earlier, despite having had three opportunities to do so. For that reason alone, plaintiff's outlier theory does not save this action from dismissal.

Even if the complaint could be read to include a claim based on this theory, it is not pled with particularity and there is no reason to relax Rule 9(b)'s specificity requirement. Citing an unpublished Eleventh Circuit opinion, *Hill et al. v. Morehouse Medical Assoc., Inc.*, No. 02-14429 (11th Cir. Aug. 15, 2003), plaintiff argues that his outlier theory is sufficient to withstand Rule 9(b) scrutiny. In *Hill*, a panel of the Eleventh Circuit reversed the district court's dismissal on plaintiff's FCA claim for failure to plead with particularity and, in so doing, distinguished *Clausen*.

Both *Hill* and *Clausen* recognized that Rule 9(b)'s heightened pleading requirements may be relaxed when evidence of fraud is exclusively within the defendant's control. *Clausen* held, however, that relaxing those requirements is not appropriate where the plaintiff can assert nothing but conclusory allegations of fraud. In contrast, the *Hill* panel found that the plaintiff's allegations were sufficiently specific, although they did

not provide patient names or dates of claims, because:

> Unlike the plaintiff in [*Clausen*], however, Hill worked in the very department where she alleged the fraudulent billing schemes occurred—MMA's billing and coding department. Thus, she has firsthand information about MMA's internal billing and the manner in which the fraudulent billing schemes were implemented. Moreover, she alleged that she observed MMA billers, coders, and physicians alter various CPT and diagnosis codes over the course of seven months and thus submit false claims for Medicare reimbursement to the government. Throughout her complaint, she identified the confidential documents within MMA's exclusive possession that contain additional evidence of fraud. In addition, she supported her legal theory with facts describing MMA's billing process, the specific CPT and diagnosis codes that were altered...and the frequency of submission of each type of claim. Furthermore, in some instances, Hill provided the names of the employees and physicians who were responsible for making the fraudulent changes and the clinics where the codes were altered. Most important, however, unlike the plaintiff in [*Clausen*], Hill was privy to MMA's files, computer systems, and internal billing practices that are vital to her legal theory, because she worked in MMA's billing and coding department for seven months.

Hill, p. 12.

Plaintiff's similarity with Hill begins and ends with the fact that he is a former employee of one of the defendants. Although plaintiff observed overbilling to *patient's* accounts, he had nothing to do with the billing process, with the submission of Medicare claims or with the Medicare payment process in general. In short, his status as a former insider did not provide him with any specific knowledge about Medicare billing or claims practices. The plaintiff in *Hill* knew from personal observation that specific information, such as patient names and dates of services, existed but could not provide it in the complaint because that information was within defendant's control. Plaintiff has asserted no firsthand knowledge to support his theory that outlier payments were increased due to a systemic practice of overcharging patient accounts. In contrast to Hill, plaintiff in this case does not know whether such information exists at all. Instead, he is more like Clausen, whose complaint fell short because he could not identify any actual claim submitted for payment, only claims that were likely or possible. *Clausen*, 290 F.3d at 1313.

Conclusion

Despite three opportunities to amend his complaint, plaintiff has failed to plead sufficiently any claim that would entitle him relief under the False Claims Act. Plaintiff has alleged that defendant Providence has engaged in a systemic practice of overbilling Medicare patients. However, the Medicare reimbursement process is a complicated one which, for the most part, is not based on the amount charged by the health care provider, and plaintiff has failed to assert any facts to demonstrate how Providence's billing practices might be material to Medicare's payment of claims. Therefore, the defendants' motion to dismiss due to be and hereby is **GRANTED.**

DONE and **ORDERED** this the 28th day of January, 2004.

S/CHARLES R. BUTLER, JR.
UNITED STATES DISTRICT JUDGE